

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
36198

1. PLACE OF DEATH
 County Cape Gir. Registration District No. 125
 Township 17 Primary Registration District No. 3009 File No. 989
 City St. Francis Hospital (N. St. Francis Hospital) Registered No. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Orla Couster

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-15-1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 ✓ ✓

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Drew

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Dora Reed

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Mr. E. W. Sanders
 (Address) Campbell mo.

15. FILED 12/16/27 W. Campbell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15 1927

17. I HEREBY CERTIFY, That I attended deceased from 12/15-27
11:30 AM to 1 PM - 12/15/27
 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Nephritis- Uterine Fibroid- Narrow Pelvis- Prolapsed cord.
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY: Instrumental Delivery
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: Campbell mo
 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____ YES
 WAS THERE AN AUTOPSY: yes
 WHAT TEST CONFIRMED DIAGNOSIS: _____
 (Signed) John P. ... M. D.
 (Address) Cape Gir. Mo.
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Campbell mo DATE OF BURIAL 12-17 1927

20. URBERTAKER E. L. Haman ADDRESS Cape Gir.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

17 1928

